2018 On-Exchange (Healthcare.gov) Individual Plans

Plan ID / Form Schedue #	59025NH0330024	59025NH0330028	75841NH0090001	75841NH0090002	96751NH0150015	96751NH0150018	96751NH0150020
Insurance Company	Harvard Pilgrim of NE	Harvard Pilgrim of NE	Ambetter (offered by Celtic)	Ambetter (offered by Celtic)	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	ElevateHealth Gold 1000	ElevateHealth Silver 3500	Ambetter Secure Care 1 (2018) with 3 Free PCP Visits	Ambetter Balanced Care 8 (2018)	Anthem Bronze Pathway X Enhanced HMO 25 for HSA	Anthem Bronze Pathway X Enhanced HMO 5750 10	Anthem Silver Pathway X Enhanced HMO 10 for HSA
Metal Level	Gold	Silver	Gold	Silver	Bronze	Bronze	Silver
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs*	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs*	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Network Coverage	Cheshire; Coos; Grafton; Hillsborough; Merrimack; Rockingham; Strafford; Sullivan	Cheshire; Coos; Grafton; Hillsborough; Merrimack; Rockingham; Strafford; Sullivan	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-Individual/Family	$1,000 per person $2,000 per family	$3,500 per person $7,000 per family	$1,000 per person $2,000 per family	$6,750 per person $13,500 per family	$5,150 per person $10,300 per family	$5,750 per person $11,500 per group	$3,000 per person $6,000 per family
Max Out of Pocket-Individual/Family	$4,000 per person $8,000 per family	$7,350 per person $14,700 per family	$6,350 per person $12,700 per family	$7,150 per person $14,300 per family	$6,650 per person $13,300 per family	$7,350 per person $14,700 per family	$6,650 per person $13,300 per family
PCP Visits	$20 copay	$40 copay	20% coinsurance after deductible	$30 copay	25% coinsurance after deductible	$40 copay with deductible; 10% coinsurance after deductible	10% coinsurance after deductible
Specialist Visits	$40 copay	$80 copay	20% coinsurance after deductible	$60 copay	25% coinsurance after deductible	%50 copay after deductible; 10% coinsurance after deductible	10% coinsurance after deductible
Urgent Care	$40 copay	$80 copay	20% coinsurance after deductible	30% coinsurance after deductible	$50 copay after deductible; 25% coinsurance after deductible	%50 copay after deductible; 10% coinsurance after deductible	$50 copay after deductible
Emergency Room	$100 copay after deductible	$300 copay after deductible	$250 copay after deductible	$150 copay after deductible	$500 copay after deductible; 25% coinsurance after deductible	$500 copay after deductible; 10% coinsurance after deductible	$500 copay after deductible; 10% coinsurance after deductible
Generic Drug	$20 copay	$30 copay	$10 copay	$25 copay	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible
Preferred Brand Drug	$50 copay	$50 copay	$25 copay after deductible	$50 copay	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible

***Ambetter has indicated that the final list of covered drugs will be able via this link no later than November 1, 2017**

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 On-Exchange (Healthcare.gov) Individual Plans

Plan ID / Form Schedule #	96751NH0150022	96751NH0150024	96751NH0150025	96751NH0150026	96751NH0150027	96751NH0150030	96751NH0150033
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	Anthem Silver Pathway X Enhanced HMO 3800 0	Anthem Catastrophic Pathway X Enhanced HMO 7350 0	Anthem Silver Pathway X Enhanced HMO 3500 0	Anthem Bronze Pathway X Enhanced HMO 6350 40	Anthem Silver Pathway X Enhanced HMO 5300 25	Anthem Silver Pathway X Enhanced HMO 2500 30	Anthem Silver Pathway X Enhanced HMO 6300 30
Metal Level	Silver	Catastrophic	Silver	Bronze	Silver	Silver	Silver
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-Individual/Family	$3,800 per person $7,600 per family	$7,350 per person $14,700 per family	$3,500 per person $7,000 per family	$6,350 per person $12,700 per family	$5,300 per person $10,600 per family	$2,500 per person $5,000 per family	$6,300 per person $12,600 per family
Max Out of Pocket-Individual/Family	$5,800 per person $11,600 per family	$7,350 per person $14,700 per family	$7,350 per person $14,700 per family	$7,350 per person $14,700 per family	$6,750 per person $13,500 per family	$7,350 per person $14,700 per family	$7,350 per person $14,700 per family
PCP Visits	$40 copay with deductible	$40 copay with deductible	$40 copay	40% coinsurance after deductible	$35 copay	$35 copay with deductible; 30% coinsurance after deductible	$40 copay
Specialist Visits	$60 copay after deductible	No charge after deductible	$50 copay after deductible	40% coinsurance after deductible	25% coinsurance after deductible	$50 copay after deductible; 30% coinsurance after deductible	30% coinsurance after deductible
Urgent Care	$50 copay after deductible	No charge after deductible	$50 copay after deductible	40% coinsurance after deductible	$50 copay after deductible	$50 copay after deductible; 30% coinsurance after deductible	$50 copay after deductible
Emergency Room	$500 copay after deductible	No charge after deductible	$750 copay after deductible	40% coinsurance after deductible	25% coinsurance after deductible	$500 copay after deductible; 30% coinsurance after deductible	30% coinsurance after deductible
Generic Drug	Tier 1: $20 copay; Tier 2: $30 copay	0% coinsurance after deductible	Tier 1: $15 copay; Tier 2: $25 copay	Tier 1: 25% coinsurance after deductible; Tier 2: 35% coinsurance after deductible	Tier 1: $10 copay; Tier 2: $20 copay	Tier 1: $10 copay; Tier 2: $20 copay	Tier 1: $15 copay; Tier 2: $25 copay
Preferred Brand Drug	Tier 1: $45 copay; Tier 2: $55 copay	0% coinsurance after deductible	Tier 1: $100 copay; Tier 2: $110 copay	Tier 1: 35% coinsurance after deductible; Tier 2: 45% coinsurance after deductible	Tier 1: $40 copay; Tier 2: $50 copay	Tier 1: $30 copay; Tier 2: $40 copay	Tier 1: $45 copay; Tier 2: $55 copay

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 On-Exchange (Healthcare.gov) Individual Plans

Plan ID / Form Schedue #	96751NH0150036
Insurance Company	Anthem Health Plans of NH
Plan Name	Anthem Gold Pathway X Enhanced HMO 1500 10
Metal Level	Gold
Plan Documents & Links	Summary of Benefits Plan Brochure Provider Directory List of Covered Drugs
Network Coverage	Statewide
Deductible-Individual/Family	$1,500 per person $4,500 per family
Max Out of Pocket-Individual/Family	$7,350 per person $14,700 per family
PCP Visits	$30 copay
Specialist Visits	10% coinsurance after deductible
Urgent Care	$50 copay after deductible; 10% coinsurance after deductible
Emergency Room	$200 copay after deductible; 10% coinsurance after deductible
Generic Drug	Tier 1: 10% coinsurance after deductible; Tier 2: 20% coinsurance after deductible
Preferred Brand Drug	Tier 1: 10% coinsurance after deductible; Tier 2: 20% coinsurance after deductible

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 On-Exchange (Healthcare.gov) SHOP Plans

Plan ID / Form Schedue #	96751NH0160005	96751NH0160006	96751NH0160008	96751NH0160010	96751NH0160011
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	Anthem Gold Pathway X HMO 1500 20 3000	Anthem Silver Pathway X HMO 3500 10 6000	Anthem Bronze Pathway X HMO 6550 0 6550 w HSA	Anthem Silver Pathway X HMO 3000 0 6550 w HSA	Anthem Gold Pathway X HMO 1750 10 3500 w HSA
Metal Level	Gold	Silver	Bronze	Silver	Gold
Plan Documents & Links	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs	Summary of Benefits Provider Directory List of Covered Drugs
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-Individual/Family	$1,500 per person $3,000 per family	$3,500 per person $7,000 per family	$6,550 per person $13,100 per family	$3,000 per person $6,000 per family	$3,500 per person $3,500 per family
Max Out of Pocket-Individual/Family	$3,000 per person $6,000 per family	$6,000 per person $12,000 per person	$6,550 per person $13,100 per family	$6,550 per person $13,100 per family	$7,000 per person $7,000 per family
PCP Visits	$20 copay with deductible; 20% coinsurance after deductible	$35 copay with deductible; 10% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Specialist Visits	$20 copay with deductible; 20% coinsurance after deductible	$35 copay with deductible; 10% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	10% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Emergency Room	$300 copay after deductible	$300 copay after deductible	0% coinsurance after deductible	0% coinsurance after deductible	10% coinsurance after deductible
Generic Drug	$25 copay	$25 copay	0% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible
Preferred Brand Drug	$50 copay; 30% coinsurance	$50 copay; 30% coinsurance	0% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 On-Exchange (Healthcare.gov) SHOP Plans

Plan ID / Form Schedule #	96751NH0160012
Insurance Company	Anthem Health Plans of NH
Plan Name	Anthem Bronze Pathway X HMO 5250 30 6550 w HSA
Metal Level	Bronze
Plan Documents & Links	Summary of Benefits Provider Directory List of Covered Drugs
Network Coverage	Statewide
Deductible-Individual/Family	$5,250 per person $10,500 per family
Max Out of Pocket-Individual/Family	$6,550 per person $13,100 per family
PCP Visits	30% coinsurance after deductible
Specialist Visits	30% coinsurance after deductible
Urgent Care	30% coinsurance after deductible
Emergency Room	30% coinsurance after deductible
Generic Drug	30% coinsurance after deductible
Preferred Brand Drug	30% coinsurance after deductible

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 Individual On-Exchange (Healthcare.gov) SADP Plans

Plan ID / Form Schedue #	57601NH0420003	57601NH0420004	57601NH0420005	87701NH0070001	87701NH0080001
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH	Anthem Health Plans of NH	Delta Dental	Delta Dental
Plan Name	Anthem Dental Family	Anthem Dental Family Enhanced	Anthem Dental Family Value	Delta Dental Family High	Delta Dental Family Low
Metal Level	Low	High	Low	High	Low
Plan Documents & Links	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory	Plan Brochure Provider Directory	Plan Brochure Provider Directory
Network Coverage	Statewide	Statewide	Statewide	Statewide	Statewide
Deductible-Individual/Family	$50 per person	$25 per person	$50 per person	$50 per person	$150 per person
Max Out of Pocket-Individual/Family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family	$350 per person $700 per family
Dental Check-Up for Children	No charge after deductible	No charge after deductible	No charge after deductible	$15 copay	$30 copay
Basic Dental Care - Child	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	$15 copay after deductible; 20% coinsurance after deductible	$30 copay after deductible; 40% coinsurance after deductible
Orthodontia - Child	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance	50% coinsurance
Major Dental Care - Child	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$15 copay after deductible; 50% coinsurance after deductible	$30 copay after deductible; 50% coinsurance after deductible
Routine Dental Services - Adult	No charge after deductible	No charge after deductible	No charge after deductible	$15 copay	$30 copay
Basic Dental Care - Adult	50% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible	$15 copay after deductible; 20% coinsurance after deductible	$30 copay after deductible; 40% coinsurance after deductible
Orthodontia - Adult	N/A	N/A	N/A	N/A	N/A
Major Dental Care - Adult	70% coinsurance after deductible	50% coinsurance after deductible	N/A	$15 copay after deductible; 50% coinsurance after deductible	$30 copay after deductible; 50% coinsurance after deductible

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 Individual On-Exchange (Healthcare.gov) SADP Plans

Plan ID / Form Schedue #	87701NH0090001	87701NH0100001
Insurance Company	Delta Dental	Delta Dental
Plan Name	Delta Dental Pediatric High Plan	Delta Dental Pediatric Low Plan
Metal Level	High	Low
Plan Documents & Links	Plan Brochure Provider Directory	Plan Brochure Provider Directory
Network Coverage	Statewide	Statewide
Deductible-Individual/Family	$50 per person	$150 per person
Max Out of Pocket-Individual/Family	$350 per person $700 per family	$350 per person $700 per family
Dental Check-Up for Children	$15 copay	$30 copay
Basic Dental Care - Child	$15 copay after deductible; 20% coinsurance after deductible	$30 copay after deductible; 40% coinsurance after deductible
Orthodontia - Child	50% coinsurance	50% coinsurance
Major Dental Care - Child	$15 copay after deductible; 50% coinsurance after deductible	$30 copay after deductible; 50% coinsurance after deductible
Routine Dental Services - Adult	N/A	N/A
Basic Dental Care - Adult	N/A	N/A
Orthodontia - Adult	N/A	N/A
Major Dental Care - Adult	N/A	N/A

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations

2018 SHOP On-Exchange (Healthcare.gov) SADP Plans

Plan ID / Form Schedule #	57601NH0390003	57601NH0390004
Insurance Company	Anthem Health Plans of NH	Anthem Health Plans of NH
Plan Name	Anthem Dental Family	Anthem Dental Family Enhanced
Metal Level	Low	High
Plan Documents & Links	Summary of Benefits Provider Directory	Summary of Benefits Provider Directory
Network Coverage	Statewide	Statewide
Deductible-Individual/Family	$50 per person	$25 per person
Max Out of Pocket-Individual/Family	$350 per person $700 per family	$350 per person $700 per family
Dental Check-Up for Children	No charge after deductible	No charge after deductible
Basic Dental Care - Child	40% coinsurance after deductible	20% coinsurance after deductible
Orthodontia - Child	50% coinsurance after deductible	50% coinsurance after deductible
Major Dental Care - Child	50% coinsurance after deductible	50% coinsurance after deductible
Routine Dental Services - Adult	No charge after deductible	No charge after deductible
Basic Dental Care - Adult	50% coinsurance after deductible	20% coinsurance after deductible
Orthodontia - Adult	N/A	N/A
Major Dental Care - Adult	70% coinsurance after deductible	50% coinsurance after deductible

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations